Understanding Alcohol & Alcoholism in Scotland

Contents

The Nature of the Problem

The most difficult things to understand are those which we take for granted. The purpose of this pamphlet is to look afresh at one aspect of Scottish life which has been taken for granted far too long. The fact of the matter is that alcohol causes some of the major problems confronting the nation today.

The trouble which is caused by the way alcohol is used in Scotland arises from the ambivalent attitudes which people hold towards it.

On the one hand, drinking is perceived as a sign of sociability and demonstrably aids communication at a wide variety of formal and informal social events. The ability to consume large quantities of alcohol is often associated with notions of toughness and maturity. A lifestyle which involves a drinking pattern of continuous heavy consumption, particularly of spirits, is sometimes seen as an indication of sophistication and urbane social mobility.

On the other hand, drunkenness, though condoned if infrequent and relatively good-humoured, is extremely threatening if the drunk person's unpredictable behaviour turns ugly in any way, either through direct aggression or through other forms of anti-social behaviour. Alcoholics, whether they are considered sinful or ill, are in either case felt to be inadequate.

Thus, alcohol is simultaneously approved and condemned. It is not even simply that it is good to drink but bad to become drunk. In some circumstances, notably at Hogmanay, drunkenness is so appropriate a mode of behaviour that sobriety is seen as a sign of prudishness. It would be difficult to monitor just how much alcohol and just what degree of drunken behaviour is considered to be right and proper for any given social occasion, but there can be no doubt that there exists in Scotland a complex scale of values that seems to shift considerably, depending upon a host of circumstantial variables.

Drug and Symbol

The source of much of the confusion and the reason for the existence of two simultaneous but contradictory attitudes is that alcohol, although a single substance, has a double identity. It is both a drug and a symbol. It is when the drug effects of alcohol are at variance with its presumed symbolic function that the greatest problems relating to its use and abuse arise.

Alcohol is a drug. Its effect is to produce initial alterations in mood, reducing anxiety and depression. Taken in small quantities, there is no reason to suppose that its effects are in any way harmful. In a complex and often stressful society such as contemporary Scotland, the existence of a socially sanctioned and

relatively safe tranquilliser is clearly going to be of considerable benefit to large sections of the population.

If, however, temporary relief from anxiety were the only drug effect produced by alcohol, this pamphlet would not be necessary. Even in the short term, alcohol reduces the intellectual functions of the brain and impairs both judgement and memory.

One of the most striking demonstrations of this relates to road accident fatalities. Of 171 drivers killed in Melbourne, Australia, it was discovered [1] that 103 had alcohol in their blood. Their blood alcohol levels are shown in Figure I.

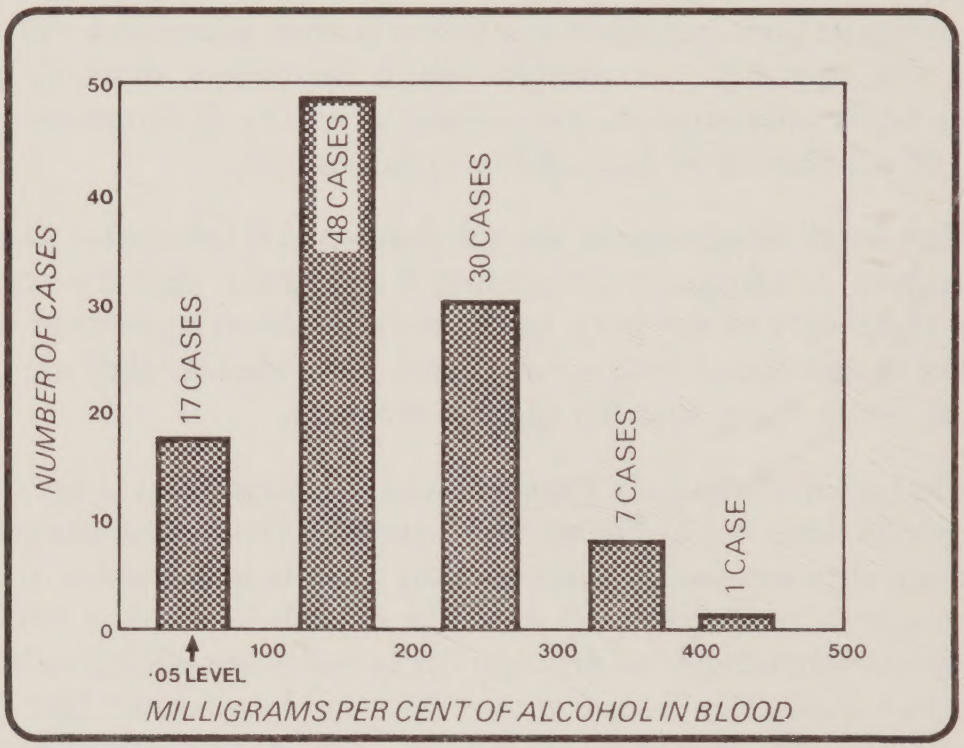

Fig. I.

It can be seen immediately that 86 drivers (50% of the total sample) had blood alcohol levels greater than 100 mg/ml.

Alcohol is a drug of dependency. This means that if sufficient quantity is taken over a long enough period of time, anybody can become addicted to or dependent upon it. In the case of some drugs, such as heroin and morphine, this quantity/frequency threshold is crossed after a very short time indeed, possibly after daily doses for only a single week. Alcohol, however, requires regular heavy consumption for a much longer period, usually a number of years, before dependency develops.

Dependency can be of two kinds: either physical or psychological. Physical

dependency or addiction can be defined accurately as that state when, if the drug is for any reason removed, withdrawal symptoms ensue. These withdrawal symptoms can range from early morning tremulousness of the hands, often known as 'the shakes', to a severe bout of delirium tremens, which can result directly in death.

Psychological dependency is less easy to define. It refers to a person's need to go on taking alcohol for psychological relief. This relief may be from anxiety, from depression, from loneliness, from boredom or from any other stressful condition. If a person needs to go on drinking in order to counteract such feelings, or if he has developed a lifestyle which includes regular heavy drinking as a necessary component, that person can reasonably be described as psychologically dependent. Not all forms of psychological dependence upon alcohol are harmful.

There is unlikely to be an absolute quantity/frequency threshold which will hold true for every individual. Nevertheless, it is possible to come to some general conclusions about how much drink is safe and at what point drinking is currently associated with risk. De Lint and Schmidt [2] working at the Addiction Research Foundation in Ontario, have surveyed the world literature on how much diagnosed alcoholics are reported to drink. They have come to the conclusion, which has also been discussed by Davies [3] of the Maudsley Hospital in London, that a reasonable estimate of that threshold would be in the region of 15 centilitres of absolute alcohol daily over an extended period of time. This is the equivalent of about five pints of beer or one bottle of sherry or just under half a bottle of whisky. It does not mean that everybody drinking that amount is an alcoholic. What it means is that, although everybody who drinks at all is at risk, this risk is greater if they regularly drink that amount or more. Those who drink less than that amount are unlikely to be defined as alcoholics.

It is only necessary to consider the widespread use of alcohol for ceremonial purposes to realise how fundamental its symbolic function is in our society.

Almost all really important events (births, christenings, weddings, funerals) tend to be linked to a deliberately ceremonial consumption of alcohol. Our cultural heritage puts a more than utilitarian value upon drinking on such occasions. It is not merely to increase sociability, but to bolster, sustain and revitalise the sense of integration of the family unit.

Perhaps even more important than the open acknowledgement of the pre-eminence of alcohol on such ritualised occasions, is the way that a host of symbolic functions relating to its use have permeated all spheres of our life. Alcohol can be a means of instigating, promoting, cementing or dissolving friendships. It can be a challenge, a provocation or even a duel. It can reach

across boundaries of race, colour and creed, or it can create new boundaries where none existed before.

The myths which surround alcohol, myths of toughness, of maturity, of sophistication, of sexuality, are manipulated continually by advertisers simply because they recognise the powerful force that such myths exert upon the drinking public. These myths were not invented by the advertisers. They are the manifestations of a set of deep-seated symbolic values which have grown and developed in Scotland over hundreds of years.

There are many reasons why drinking should play such a disproportionately important part in the cultural life of Scotland. It has been suggested [4] that alcohol consumption rates tend to be particularly high where there is (a) social pressure to imbibe (b) inconsistent or non-existent social sanctions against excessive drinking (c) drinking outside a family or religious setting and (d) ambivalence towards moderate drinking. All these conditions are fulfilled in Scotland today. When they are viewed in the context of a rigorously enforced protestant ethic, a fierce and sometimes embittered patriotism and a comparatively inimical climate, it is easy to see how the functional aspects of drinking behaviour have become inextricably tangled with a host of compensatory and guilt-provoking feelings. These have acquired separate symbolic associations and have served to make drinking an activity qualitatively of considerable importance to the self-esteem of the individual and of the nation.

When you take a drink, you are not simply consuming a measurable quantity of ethanol, which will produce a predictable pattern of bio-chemical and behavioural changes. You are also participating in an act which society, and you, have invested with a myriad of special meanings, depending upon the circumstances in which you are drinking. The giving and receiving of alcohol is a symbolic indication of a wish to extend friendship and closeness. Hence the disdain in which the man who refuses a drink is held, and hence the elaborate rules which govern the custom of buying 'rounds'.

It is not simply because alcohol has a disinhibiting effect upon aggressive tendancies that violence is often associated with it. Drinking, like sex, is a very special kind of activity. Its symbolic value and the importance that the individual attaches to his particular performance is in direct proportion to the value and importance accorded to that activity by society itself.

Consumption

De Lint [5] who was mentioned above, has suggested that it is possible to predict the number of alcoholics (or, in his terms, those people most at risk of damaging themselves because of their excessive drinking) in any society, if you know the

average per capita consumption in that society. In Figure II the daily consumption of absolute alcohol expressed in centilitres along the horizontal axis of the graph is related to the percentage of consumers along the vertical axis.

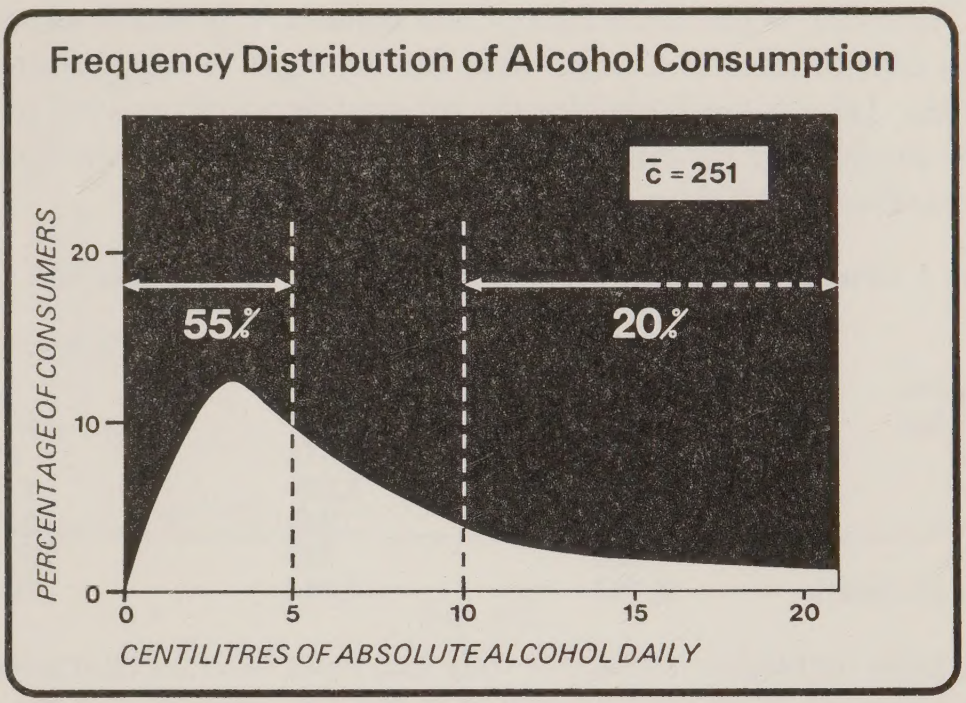

Fig. II.

The curve, which is known as a logarithmic normal curve, shows the relationship when the per capita consumption of the population is 25 litres of absolute alcohol per annum. In such a population, about 55% of the drinkers consume quite small quantities of alcohol (5 centilitres or less daily) while 20% consume at least 10 centilitres daily.

If per capita consumption is 15 litres of absolute alcohol per annum, this reduces to 9% the number of people drinking more than 10 centilitres daily. Remember that 15 centilitres of absolute alcohol daily had been suggested as the possible quantity/frequency threshold for alcohol abuse. A fall in total consumption is therefore going to diminish proportionally the number of potential alcoholics.

Total consumption [6] of spirits in the United Kingdom rose from 19 million proof gallons in 1964-65 to 32 million proof gallons in 1973-74. Consumption of wine in the same period increased from 27 million gallons to 68 million gallons. Increases in beer consumption are less dramatic but the total figures for this nine-year period represent an increase in beer consumption of 33%, an increase in spirit consumption of 68% and an increase in wine consumption of 152%.

Since the size of the population has remained relatively stable during this period, these figures represent a massive increase in average per capita consumption. The implication is therefore that there has been a corresponding increase in the number of people at risk of becoming alcoholics and in the number of people suffering various kinds of severe damage as a result of their drinking. In order to put these figures into context, it is useful to compare the increase in expenditure on alcohol with the increases in expenditure on other commodities. Data is available [7] for the ten-year period from 1963 to 1973 and, in order to compensate for inflationary factors, prices for the whole period have been standardised at 1970 levels.

Table 1 **Consumers' Expenditure: United Kingdom (1970 prices £m)**

	1963	*1973*	*% increase*
Tobacco	**1,774**	**1,859**	**4·8**
Clothing	**2,243**	**3,023**	**34·8**
Food	**5,994**	**6,374**	**6·3**
Beer	**1,064**	**1,586**	**49·1**
Spirits	**468**	**948**	**102·6**
Wine	**220**	**550**	**150·0**
Alcohol (total)	**1,752**	**3,084**	**76·0**

What this table highlights is that not only has there been an enormous increase in the total amount of alcohol consumed in the UK over the last ten years, but that there has been an increase in expenditure on drink which is considerably greater than the increases on other commodities.

At the same time, the real cost of alcohol has diminished significantly and steadily over the same period. Figure III [8] plots the per capita consumption of whisky throughout the UK against the price of a standard bottle, expressed as a percentage of disposable income. Personal disposable income is what is left after deduction of taxes and statutory contributions.

The point made by de Lint and Schmidt is that increases in total consumption will result in increases in the numbers of probable alcoholics. Data [8] for the same period is available which corroborates this hypothesis and makes it particularly relevant to Scotland. Figure IV shows the changes in consumption of whisky and its relative cost in the UK from 1950 to 1970 together with the rate of admission for alcoholism to Scottish hospitals since 1956.

It is difficult to ignore the similarity of the curves illustrating consumption and hospital admission, as opposed to the converse curve illustrating cost. Obviously, this is not a simple case of cause and effect. Many other factors will influence the situation. At the same time, however, it is clear that as the individual pays less for his bottle of whisky, so the total cost to society increases in terms of alcoholism and all the human suffering that accompanies it.

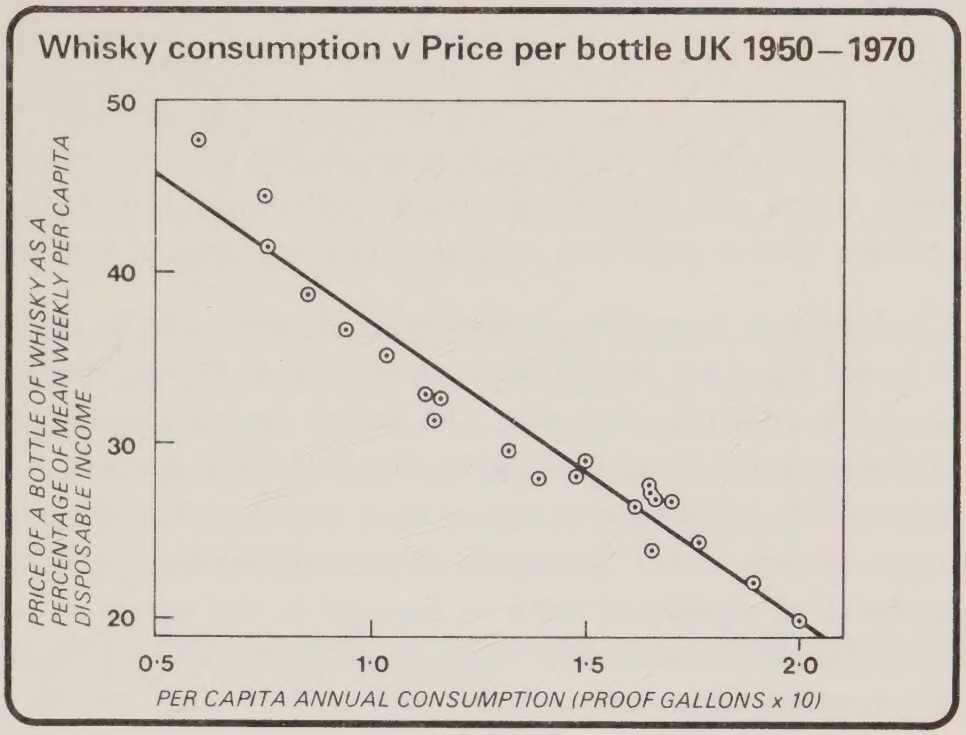

Fig. III.

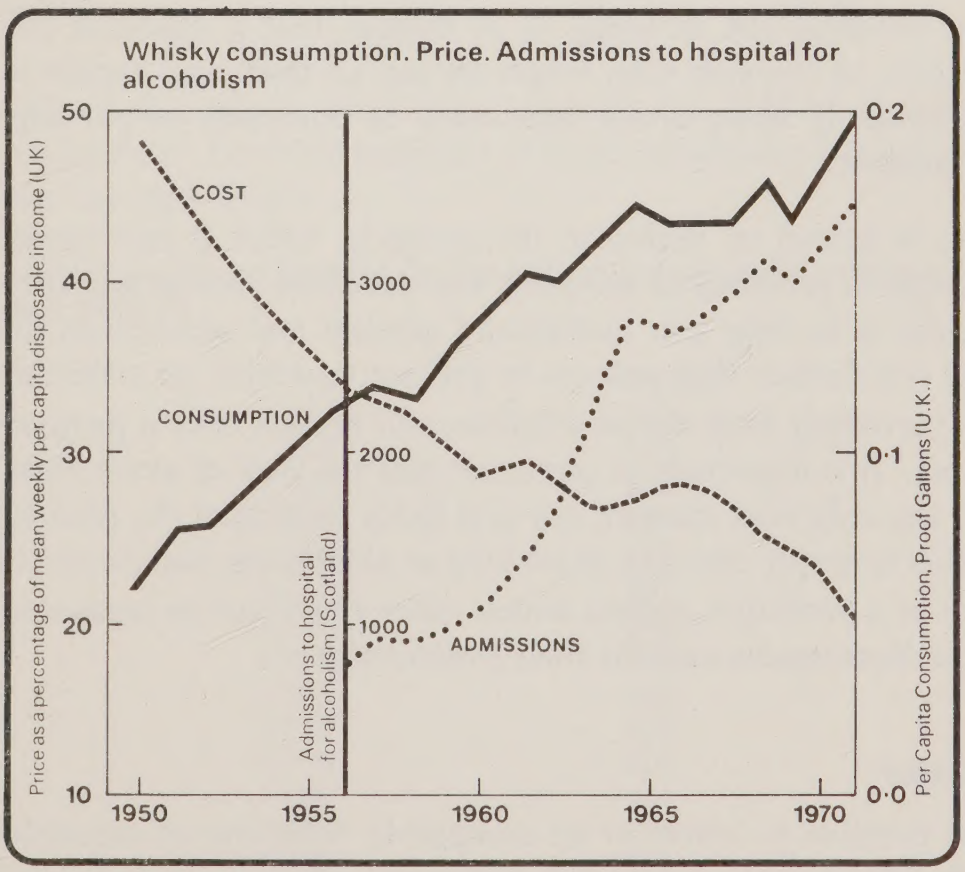

Fig. IV.

Alcoholism

Many people who are to some extent dependent upon alcohol, may do themselves little or no harm by it. Others, however, may get into very severe difficulties as a result of their drinking. It is impossible to give a single definition of alcoholism, which will satisfy everybody. Alcoholic is the word used to describe a person who is perceived as requiring some kind of treatment.

Although a definition is impossible, a number of elements can be identified which most people would agree are important in attempting to decide whether or not an individual should be called an alcoholic. The first of these is alcohol. A pattern of continuous or intermittent excessive consumption is the *sine qua non* of alcoholism. Secondly, it would be reasonable to expect some evidence that the individual was dependent upon alcohol, either physically or psychologically. And finally, there should be evidence of significant harm or damage in any aspect of life, whether physical, psychological or social. It is likely that it is only when all three conditions are met (consumption, dependence, harm) that an individual will be labelled an alcoholic.

It is often convenient to think of alcoholism as a disease. This certainly has greater advantages than considering it as a moral weakness, which is how it used to be viewed. The difficulty is, of course, that it channels the alcoholic into the luxury of the sick role, where he can sit back and expect to be cured without necessarily being either motivated or equipped to participate in the treatment process.

Alcoholism is indeed so varied in the forms in which it can appear that the greatest danger is probably in adopting any doctrinal view at all. If the point of this pamphlet is to help you understand alcohol and alcoholism in Scotland, then it will not further that process to present you with an artificial definition which will inevitably limit the possibilities and include only a proportion of the real sufferers. It is important to point out that the view of alcoholism advanced here is not the only view current, nor is it likely to present the final word on the subject. This is simply one way of looking at alcoholism and its most important use may be as a yardstick against which other views can be measured, both for their comprehensiveness and for their practicality.

Prevalence

If it is not possible to arrive at an acceptable definition of alcoholism, this is clearly going to present considerable difficulties when it comes to attempting to produce estimates of its prevalence. The attempt is further complicated by the fact that the majority of alcoholics are undetected.

In the Report of the Departmental Committee on Scottish Licensing Laws [9] Clayson suggests that 2% of the population over 15 years old are likely to have significant drinking problems, although probably only a third of these people will actually be alcoholics. Whittet [10] has suggested an alcoholism rate of 1·11% for males and 0·15% for females in the Highlands and Islands. Other studies [11] from England and Wales would tend to corroborate that the total rate is very unlikely to be any less than these estimates.

Since it is so difficult to count alcoholics in the general population, a number of indirect indices are used to compute the likely prevalence of the condition. Deaths from cirrhosis of the liver is one such method, as is the rate of hospital admissions for alcoholism. Certainly, it is important to notice that there are differences by region within Scotland in these rates. Figures [12] for the year 1972 show just how significant these differences are:

Table 2 **Admissions to hospital for alcoholism and alcoholic psychosis in Scotland 1972. Rates per 100,000 of population**

	Males	*Females*	*Overall*
North	**442·6**	**74·9**	**255·6**
North East	**127·9**	**18·0**	**70·7**
East	**130·3**	**41·8**	**84·0**
South East	**77·1**	**21·5**	**48·1**
West	**140·1**	**35·7**	**86·0**

Taking Scotland as a whole, alcoholism accounts for 20% of all admissions to psychiatric hospitals. The total numbers of these admissions has been increasing steadily since the mid-1950's :

Table 3 **Admissions to hospital for alcoholism and alcoholic psychosis in Scotland 1956-71**

Year	*Male*	*Female*	*Total*
1956	**610**	**122**	**732**
1957	**727**	**113**	**840**
1958	**727**	**134**	**861**
1959	**796**	**125**	**921**
1960	**920**	**171**	**1,091**
1961	**1,160**	**187**	**1,347**
1962	**1,340**	**277**	**1,617**
1963	**1,959**	**348**	**2,307**
1964	**2,263**	**435**	**2,698**
1965	**2,175**	**435**	**2,610**
1966	**2,336**	**419**	**2,755**
1967	**2,469**	**434**	**2,903**
1968	**2,617**	**464**	**3,081**
1969	**2,437**	**511**	**2,948**
1970	**2,598**	**582**	**3,180**
1971	**2,888**	**756**	**3,644**
1972	**3,395**	**887**	**4,282**

Since precise data on total prevalence figures for Scotland are not currently available, it is impossible to do more than reinforce the estimate advanced by Clayson. If his figure is accepted, this means that at least 75,000 people in Scotland are experiencing problems as a result of their drinking. **Although it would of course be convenient to have more accurate information, its absence should not prevent us from recognising the incontestible fact that alcohol abuse is one of the greatest problems facing Scotland today.**

Causes

A necessary condition of alcoholism is alcohol. Enough has been said already about its properties both as a drug and as a symbol to make it abundantly clear that, whatever its benefits, alcohol is itself an extremely dangerous substance. Obviously Scotland has made an historical decision, at least by implication, in the attitude which it has adopted to alcohol and which it expresses in a particular social, legal and fiscal framework. In general, this decision is expressed in the notion that the benefit enjoyed by the majority is more important than the suffering experienced by a minority.

Living as we do with a suffering minority of 75,000 individuals, to say nothing of their families and friends, it is perhaps reasonable to ask not only what can be done to minimise the suffering or reduce the number of sufferers, but also, given that alcohol is potentially equally available to all, why those particular individuals have become the casualties.

The first and shortest answer is probably because they drank most. It is more relevant, when examining causation in depth, to enquire not: how did this man become an alcoholic? but rather: what caused this man to drink so much that he became an alcoholic? It may often be considerably easier to answer the second question than the first.

A large number of factors influence the way people drink and therefore have a bearing upon whether or not they become alcoholics. These facts can be grouped under two broad headings: firstly, cultural or social factors, and secondly, psychological or internal factors.

It is well known that there are considerable differences between the way alcohol is used in various cultures and that these differences seem to produce considerable variations in alcoholism rates. In Ireland, for example, where heavy drinking is encouraged, drunkenness is tolerated, most drinking takes place outside the family and is not associated with other activities such as eating, there is a particularly high rate of alcoholism. Jews, on the other hand, drink almost exclusively within the family context and do so in a moderate and ritualised way. Alcoholism rates amongst Jews are particularly low. American

Mormons, on the other hand, totally prohibit the use of alcohol; yet amongst those who *do* drink, the rate of alcoholism is extremely high. Scotland is generally reckoned to have an alcoholism rate four times that of England and the Highlands and Islands twelve times that of England. Such striking differences cannot be ignored and it seems more than likely that they represent not some biochemical proclivity towards alcoholism in particular racial groups but rather a nexus of socio-cultural attitudes which make certain kinds of drinking behaviour more or less appropriate to most people born into any particular culture.

People working in certain occupations are also known to run a much higher risk of becoming alcoholics. In Table 4 [13] you can see the death rates from cirrhosis of the liver for various occupations.

Table 4 **Deaths from cirrhosis in different occupations in England and Wales**

	Standard Morality Ratio
Company Directors	**2,200**
Publicans	**773**
Actors and Entertainers	**550**
Hotel Keepers	**450**
Armed Forces	**350**
Medical Practitioners	**350**
Barmen	**200**
Commercial Travellers	**150**
Total male population of England & Wales	**100**

There are three features which most of these occupations have in common. The first is the availability of free or cheap alcohol. The second is a relative freedom or lack of supervision. The third is a greater than average separation from the stabilising influence of the home. It could of course be argued that potential alcoholics will tend to join these occupational groups in order to ease their problems of supply, but it is surely more likely that the causative relationship works in the opposite direction, particularly when it is borne in mind that the natural history of alcoholism is of a relatively slow progressive condition which usually involves a gradual build-up in quantities being drunk over a number of years. Even although the average age at which alcoholics present themselves for treatment is dropping, it is still true that the commonest age is in the early to mid-40's.

Drinking, as has been suggested already, is a form of habitual behaviour and therefore, like other habits, it has to be learned and reinforced. People learn best by imitation and it seems likely that the drinking behaviour of any individual is influenced most strongly by the drinking behaviour of others close to him—his family and, more particularly, his friends. A degree of uniformity in an important activity like drinking is a strong force for social cohesion. It is hardly coincidental that the majority of people in our society regard total

abstinence with suspicion and believe that the fact that abstainers show deviance from the norm in terms of their drinking behaviour is likely to be a sign of inadequacies in other forms of behaviour.

As habitual behaviour becomes what psychologists call functionally autonomous, that is to say when the habit begins to take on a life of its own, we move over from the socio-cultural factors influencing drinking habits to those factors which have to do more with the personality of the individual. There is, as far as we know, no such thing as an alcoholic personality. Nevertheless, people with certain kinds of personalities are obviously more likely to drink excessively than others. This is, however, an extremely difficult area in which to come to any meaningful conclusions, because of the lack of objective scientific criteria. Notions such as 'personality disorders' or 'oral fixations' are likely to prove less than helpful in understanding the aetiology of alcoholism.

Stress is frequently invoked as the major cause of alcoholism. Given the drug effect of alcohol, its use to relieve stress is clearly of great importance and it may be that many people use alcohol excessively because their life is in some way unbearably stressful. Poverty, overcrowding, family responsibilities, difficulties in marriage, sex or work, loneliness, the state of the nation: anything, in other words, might be the stress. Since the coping mechanism of alcohol is sanctioned by society, the individual could certainly drink in such a way that he becomes in time an alcoholic. What this means is that for many alcoholics there may be no clear-cut distinction between the causes of the condition and the effects of the condition. If alcohol is used as a means of attempting to solve problems, it is likely to exacerbate rather than diminish the difficulties encountered. The more excessive the drinking, the greater the problems are likely to become; and the more excessive still, in turn, becomes the compensating drinking. The alcoholic becomes caught up in a vicious circle where the distinction between cause and effect becomes so blurred as to be almost meaningless. Problems lead to drinking, which leads to greater problems, which lead to more drinking. Or drinking leads to problems, which lead to greater drinking, which leads to more problems. It is the decision of individual therapists to choose the most relevant point of entry into this vicious circle for each alcoholic whom they are called upon to help.

Finally, it is important to note that there is no good evidence, despite exhaustive research, that there are important genetic factors or biochemical abnormalities which would mark out those most at risk. Indeed, on the basis of what we have already seen, it is clear that there is no single cause of alcoholism. A host of different factors combine in different convolutions to produce this elusive but widespread condition. There is, if you like, no such thing as alcoholism. There

are many different alcoholisms, each subtly but significantly different from the next, each having a different pattern of causation and perhaps requiring a different kind of treatment.

Effects

Before examining the harmful effects consequent upon excessive drinking, it is important to re-emphasise that for the majority of people the effects of alcohol are by and large beneficial. This is important to remember because it has implications both in terms of prevention and of treatment. What we should be concerned to do is to make available the beneficial effects of alcohol but at the same time to eliminate the harmful effects.

An obvious area in which harmful effects may be experienced is in terms of the physical consequences of excessive drinking. These may of course relate either to a single episode of intoxication or to a pattern of continuous heavy drinking over many years.

It is well known that people are more likely to have accidents while they are drunk. Everything from simple cuts and bruising as a result of falling over, to multiple deaths in motorway pile-ups can result from the acute short-term effects of alcohol. It is necessary to distinguish between these and the more chronic long-term effects.

Continuous heavy drinking is often accompanied by loss of appetite and a tendency to substitute alcohol for other more nourishing forms of food. Not infrequently, alcoholics suffer from severe vitamin deficiencies, which may in turn lead to conditions such as peripheral neuropathy. They may also of course develop liver cirrhosis. The death rate for alcoholics is at least twice that of the general population. They die not only from cirrhosis, pneumonia, heart disease and accidents, but also from suicide. The suicide rate for alcoholics has been carefully researched [14] and is reckoned to be approximately 76 times that of the general population.

Suicide clearly relates to the psychological effects of excessive alcohol consumption. Alcoholics are frequently very depressed and are subject to feelings of remorse and lowered self-esteem. Sexual problems, such as impotence and morbid jealousy, are sometimes associated with this. Alcoholics also tend to experience regular memory losses so that they are unable to remember in the morning what happened the night before. More rarely, alcoholic hallucinosis, in which auditory hallucinations are the main symptom, and Korsakoff's psychosis, in which the individual fills gaps in his memory with confabulations, can also occur.

In many ways, however, the most strikingly harmful consequences of excessive drinking are in the social sphere. The effect of alcoholism upon the family is often quite disastrous and marital breakdowns are frequently related to alcoholism. A similar relationship between alcoholism and baby-battering has been suggested. The children of alcoholics are considerably more disturbed than the children of non-alcoholic parents and 48% present severe behaviour problems at school [15].

These social consequences obviously produce extreme suffering for the families in which they occur. It is, however, also possible to quantify them on a national

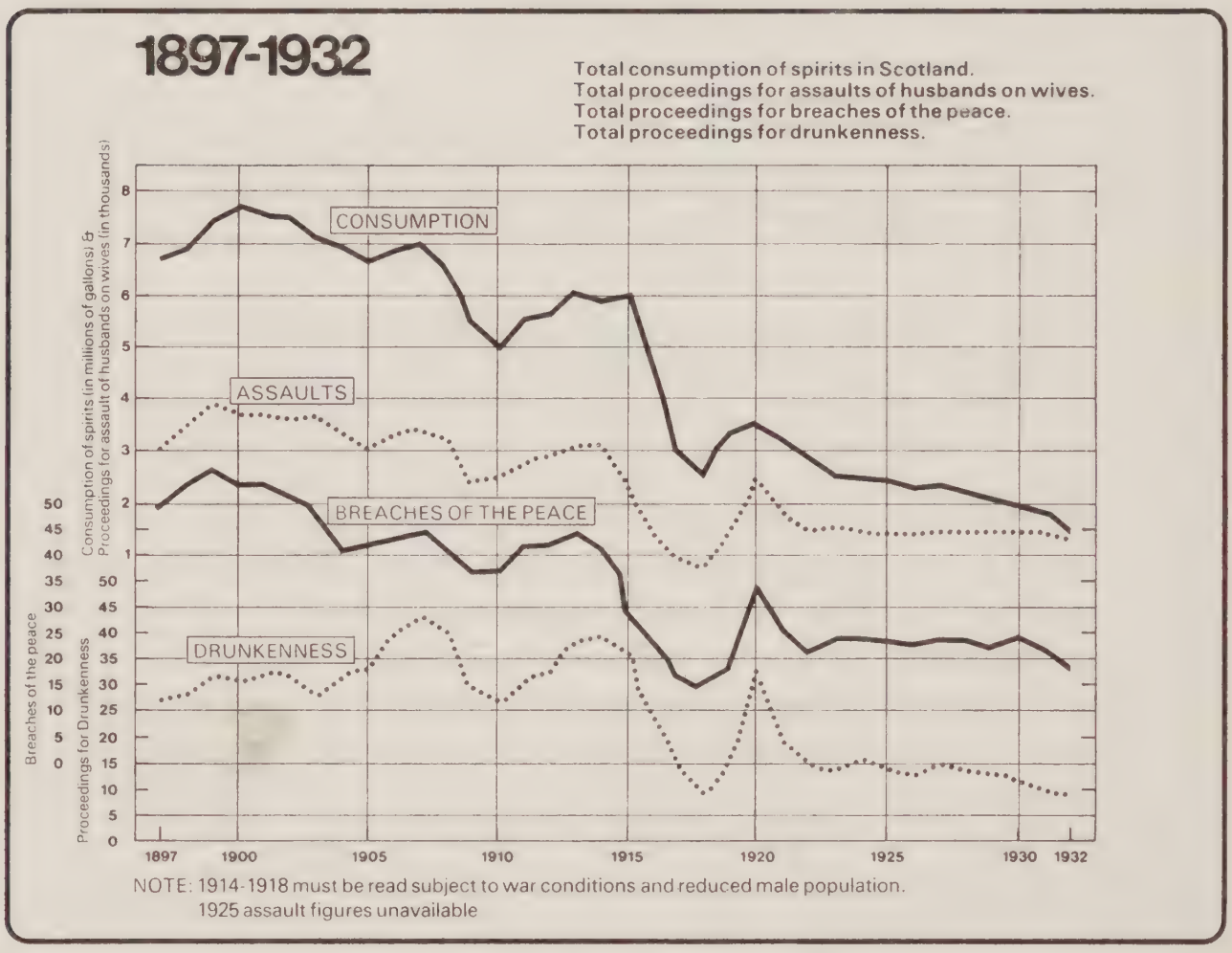

Fig. V.

scale. This was undertaken in Scotland for the years 1897 to 1932 [16] and Figure V shows the relationship between the following phenomena:

1. Total consumption of spirits in Scotland.
2. Total proceedings for assaults of husbands on wives.
3. Total proceedings for breaches of the peace.
4. Total proceedings for drunkenness.

The close similarity between these four curves over such a long period makes it

difficult to avoid the conclusion that there must be some kind of causative relationship between drinking and wife-beating.

Alcoholism causes considerable problems not only in relation to the family but also in relation to efficiency at work. For the individual, such significant drops in work performance, usually associated with increased absenteeism, may well result in demotion or dismissal. Many alcoholics show evidence of frequent changes of job and lengthy periods of unemployment. For Scottish industry as a whole, it has been estimated [17] that alcoholism costs a sum approaching £35 million each year (arising from absenteeism, loss of training investment, accidents, reduced output and quality and errors in judgement).

There is also good evidence to suggest a significant relationship between alcoholism and crime. In terms simply of offences relating to drunkenness, rises in the rate of convictions seem to keep pace both with rises in total consumption and rises in rates of admissions to mental hospitals for alcoholism. Table 5 shows the totals of all drunkenness convictions [18] (including in charge of a motor vehicle) for Scotland.

Table 5 **Drunkenness convictions in Scotland**

	1961	*1971*	*1973*
Drunkenness*	**9,713**	**10,898**	**13,516**
Motor Vehicle Offences	**2,877**	**9,799‡**	**11,580**
Other Offences†	**928**	**1,555**	**1,817**
	13,518	**22,252**	**26,913**

* includes drunk and incapable and drunk and disorderly.

† includes selling drink to a habitual drunkard, selling drink to a person under 18 and employing a person under 18 to sell drink.

‡ a major factor influencing this particularly sharp increase was the introduction in 1967 of the breathalyser test.

It is not only in terms of drunkenness offences that the effects of excessive drinking are apparent. It has been suggested [19] that at least 40% of all male inmates of prisons are excessive drinkers and it has long been recognised that recidivists are especially likely to have drinking problems. Balfour Sclare in Glasgow has found that 70% of assailants have been drinking in the four hours before committing a murder.

It is perhaps important to point out that the stereotype of the skid-row alcoholic, or meths-drinking vagrant, represents only a tiny fraction of the total alcoholic population of Scotland, possibly as little as 2%. The majority of alcoholics, despite severe social harm and damage of many kinds, do not in fact become destitute. At the same time, a high proportion of destitutes are indeed alcoholics.

Two other special groups within the general population have recently attracted particular attention. The number of women alcoholics presenting for treatment appears to be increasing at a proportionally faster rate than the men. Many reasons have been suggested for this but the most important would seem to be the change in social attitudes which has made it acceptable for women to drink on a more equal basis with men, together with an increased availability of alcohol through the growth in retail outlets situated in supermarkets.

The other group which has attracted particular attention is young people. The work of Stacey and Davies [20] of Strathclyde University leaves little doubt that drinking is normal behaviour for the vast majority of teenagers before they reach the legal age limit for the purchase of alcoholic beverages.

Although it is unlikely that very many teenagers will be alcoholics in the sense in which the term has been used throughout this pamphlet, there clearly are dangers in a trend of increasing consumption amongst the young, both in terms of their habituation to alcohol and its possible long-term effects, and more particularly, in terms of the short-term effects of drunkenness. Young people are recognised as having a reduced tolerance to the effects of alcohol and it is likely that the kind of casualties which might result from bouts of intoxication could be extremely serious. The percentage of men who die in Scotland as a result of road accidents [21] is 1·8 per 100 deaths from all causes. For those aged between 15 and 24 the percentage is 33·2 per 100 deaths from all causes. Young people are, therefore, particularly vulnerable.

Prevention

If, as was asserted at the beginning of this pamphlet, many of the problems resulting from the abuse of alcohol in Scotland today are the result of the ambivalent attitude which our society holds towards alcohol, then it would seem reasonable for preventive strategies to concern themselves with eradicating the confusion and encouraging a more straightforward approach.

The researches of Jahoda [22] would certainly indicate that children are forming their attitudes to alcohol at a very early age and it may be that health education during the first few years of primary school would be more effective than the more common practice of delaying it until the final years of senior school, when the child is likely already to have established a particular pattern of drinking. However, Jahoda and Davies and Stacey agree that learning within the home is the most important formative influence. Alcohol education for the young is generally known as primary prevention and has as its aim the communication of a realistic and unambiguous set of values relating to drinking.

At the same time, however, educational activity with regard to the young should not blind us to the pressing need for strategies of secondary prevention which could be used with the population as a whole. Recalling the logarithmic normal curve of de Lint and Schmidt (Figure II) it would seem reasonable to concentrate effort upon those people who are most at risk, namely those whose daily drinking is heavy enough to place them close to the 15 centilitres of absolute alcohol cut-off point on the right of the graph.

Although not all people drinking this amount will necessarily be damaging themselves, they are of course much more likely to do so than those who drink less. It is important to emphasise that preventive strategies need not be concerned with eliminating dependency or promoting abstinence. The stabilisation of drinking at an acceptable and damage-free level may be a much more realistic goal.

In this way, help can be made available where it is most likely to be required. This leads on to tertiary prevention, where the aim is more specifically to do with motivating those who are known to be damaging themselves into accepting some form of appropriate treatment.

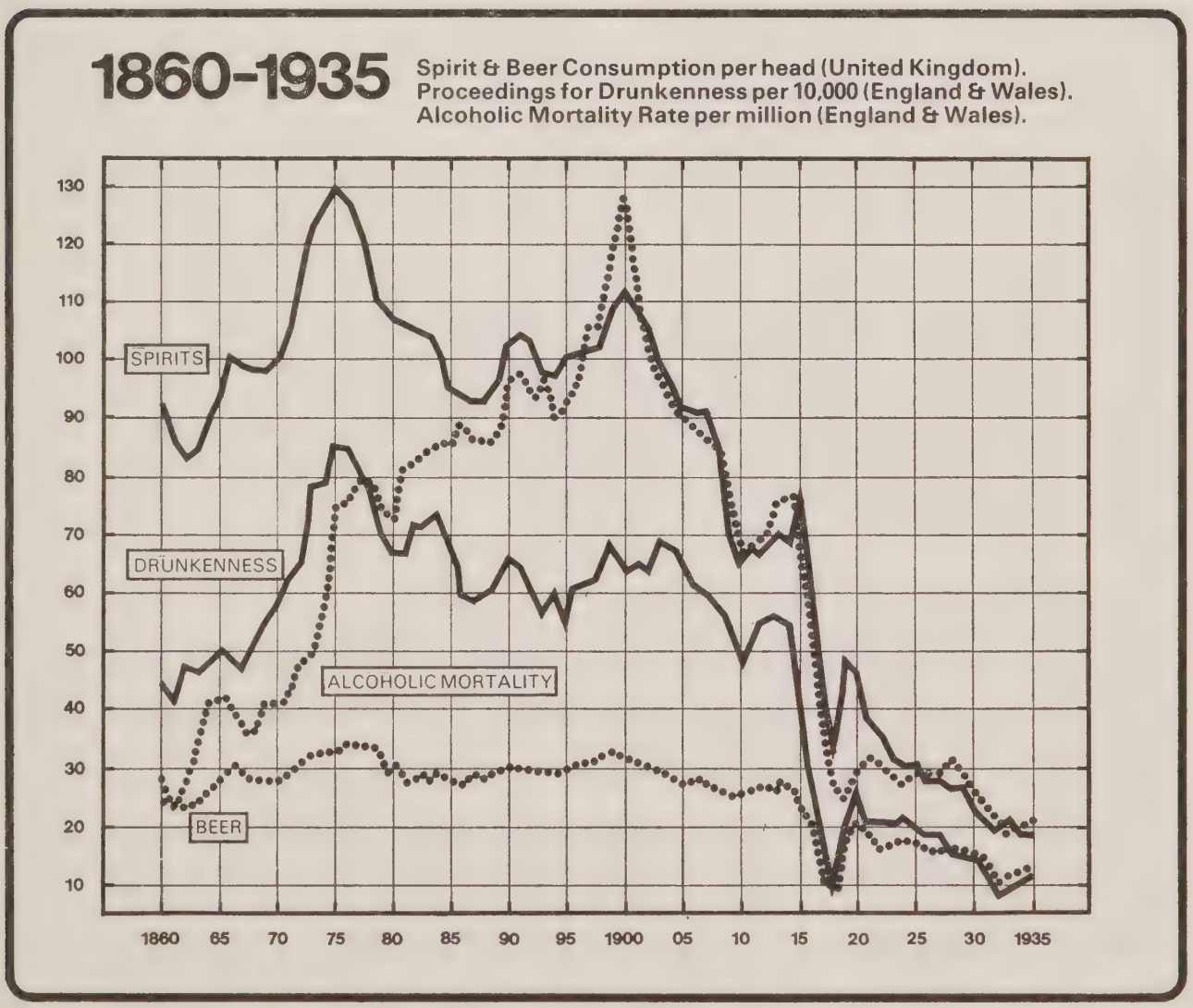

Fig. VI.

Prevention is not, of course, simply a matter of education. Legal measures, such as changes in the liquor licensing laws, fiscal measures, such as changes in the tax levied on a bottle of whisky, and social measures, such as changes in the environmental ethos of public houses, may all be equally or more effective. Again, evidence from earlier in the century may be of significance [16]. Figure VI shows the relationship between consumption of spirits and beer, proceedings for drunkenness (per 10,000) and alcoholic mortality rate (per 1,000,000) for the years 1860 to 1935.

The most remarkable feature of this graph is the dramatic drop in all four rates which coincides with the period of the first world war. Clearly, many factors might contribute to this phenomenon, not least of which was the absence of a large section of the young male drinking population, who were occupied in the trenches in Flanders. At the same time, however, it is important to remember that Lloyd George was so appalled by the drunkenness amongst munitions workers, which was preventing necessary armaments reaching the troops on the front, that he stated: 'This country is fighting two enemies: drink and the Kaiser. In that order'. It was for this very reason that Parliament passed the Defence of the Realm Act, which introduced licensing laws as we now know them. Dr T. H. C. Stevenson, the Medical Statistician to the Registrar-General's Department, commenting on the above figures, said: 'All the indices available show the same feature of a sudden reduction on the outbreak of war, of which much the simplest and therefore the most acceptable explanation appears to be the increased difficulty from that time onwards of procuring alcohol'.

In a society like Scotland today, where total consumption figures are rising steadily, drawing with them increasing rates of drunkenness and alcoholism, the question to be asked is simply what sort of price we are prepared to pay to minimise the social disruption and suffering which alcohol is causing. It is not a question to be ignored and it is one which becomes the more urgent with every delay in coming to an answer.

Treatment

Almost all the treatment available for alcoholics in Scotland today involves counselling of one form or another. There is, in other words, no wonder-cure for alcoholism. Alcohol-sensitising drugs, which produce extremely unpleasant symptoms if the patient drinks alcohol while undergoing the treatment, are sometimes used to reinforce abstinence. Various other drugs are used in hospital to aid the process of detoxification. Aversion therapy is practised very occasionally and there is now a growing reluctance to prescribe tranquilisers and anti-depressants for alcoholics because of the dangers of dependence on these drugs. Basically, what is done for alcoholics is done by talking to them,

whether this takes the form of counselling or psychotherapy with individuals or in groups. Whether this takes the form of individual or group psychotherapy, there can be little doubt that, given our present state of knowledge and level of skills, the relationship which a therapist builds up with an alcoholic and possibly also with the alcoholic's family represents the best investment in a healthy future for that alcoholic.

Apart from during the period of withdrawal from alcohol, when the individual may develop delirium tremens or other complications, there is no evidence that doctors are necessarily particularly better qualified to counsel alcoholics than are any other trained workers. What is much more important is a tolerant and well-informed approach to the alcoholic and his problems.

For most alcoholics, the outcome of a successful treatment programme is total abstinence from alcohol. There is now, however, growing evidence to suggest that a proportion of alcoholics, probably a comparatively small proportion, can return to what is usually called 'normal social drinking'. It should be remembered that the most common goal of treatment is to prevent the alcoholic continuing to harm himself. This may or may not be the same thing as stopping him drinking. It should be added that many alcoholics will probably find it easier to achieve a goal of total abstinence than successfully to reduce their alcohol consumption.

The two traditional treatment agencies are psychiatric hospitals and Alcoholics Anonymous. In Scotland there are five hospitals with specialised units for the treatment of alcoholism. These are:

Bellsdyke Hospital (Forth Valley Health Board)
Crichton Royal Hospital (Dumfries and Galloway Health Board)
Royal Edinburgh Hospital (Lothian Health Board)
Southern General Hospital (Greater Glasgow Health Board)
Sunnyside Hospital (Tayside Health Board)

There are in addition thirteen other psychiatric hospitals or psychiatric units in general hospitals which have a special interest in alcoholism.

Alcoholics Anonymous is a self-help organisation which provides its members with a social structure to fill the gap previously occupied by drinking and gives their lives purpose through aiding others to achieve abstinence. Recently, Al-anon and Al-Ateen groups have been established to assist the families of alcoholics.

Increasingly today opinion is moving towards the establishment of a more broadly based system of community services for alcoholics. The emergence of the Scottish Council on Alcoholism with its affiliated local Councils in Glasgow, Edinburgh, Aberdeen, Clydebank and Tayside is an important step in this

direction. At a local level, these Councils are coming to be viewed as focal points within the communities which they serve. They can perform a co-ordinating function in terms of facilities and services as well as acting as information centres and treatment and referral points. The Scottish Council on Alcoholism is the voluntary body, which has an overall responsibility and an advisory role in the formation of policy and strategies for prevention, treatment and the development of services for alcoholics.

Ideally, the special needs of the alcoholic would be best served by an integrated system of hospitals, day-clinics, hostels and information centres, together with a well-informed body of nurses and doctors in hospital, general practice and in community health, social workers, clergymen, teachers and all others who come into contact with the problems raised by alcoholism, whether in a professional or a voluntary capacity.

Conclusion

In the absence of this ideal system of treatment agencies, it is essential that all those who come into contact with alcoholics and their families should seek to offer what help they can and strive to remain fully informed about the subject. It is equally essential that every effort should be made to prevent people ever becoming alcoholics.

If you have read this pamphlet, then you have shown interest in developing your awareness of what alcoholism is and how you can be of most help. The next step is to make others equally aware.

If you are professionally involved in the problems caused by alcoholism, you can help to upgrade your skills and the skills of your colleagues by pressing for more relevant training programmes in alcoholism for your particular profession. Social workers, general practitioners, community physicians, psychiatrists, general physicians, nurses, health visitors, health educationalists, teachers, psychologists, magistrates, judges, policemen, prison officers, clergymen, social scientists, personnel from the armed forces, industrial personnel and welfare officers, youth officers and many, many more are coming into frequent contact with alcoholics. Yet the majority have received little or no education in the subject or training in how they can be of most help.

If you wish to become involved with helping alcoholics in a voluntary capacity, a new training scheme for voluntary alcoholism counsellors is being set up by the Scottish Council on Alcoholism, the Scottish Health Education Unit, Glasgow University Department of Social Administration, Social Work Services Group and the Scottish Marriage Guidance Council.

If community facilities are to develop on a local basis to answer local needs then this can only happen when all those interested people in each area come together and plan how best they can contribute to an effective alcoholism service. It is not sufficient to wait for the Government to take the initiative or for hospitals or social work departments to show the way. It is the responsibility of every individual who feels any concern for the plight of the alcoholic in Scotland today.

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